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ORIGINAL ARTICLE

The Phenomenological Auditory Hallucination Scale, second version (PAHS.2)

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ABSTRACT

This report is about to present the second version of the Phenomenological Auditory Hallucination Scale (PAHS.2). This is an instrument designed for clinical practice and psychopathological research. Our main aim was to explore hallucinations with a specific attention to qualitative subtle features that often are crucial for the assessment. The scale was designed to assess not only the intrinsic features of hallucinations but also the context in which they are situated (e.g., the state of consciousness, the surrounding atmosphere, the experience of time, etc.).

A first version of this scale (PAHS.1) has been discussed at the Roman Circle of Psychopathology, then sent for public consultation (to clinicians and experts by experience). Moreover, the authors administered it to a small sample of patients (with psychosis, PTSD and substance-related hallucinosis) to detect possible difficulties in single items' questions and/or possible answers. In two subsequent meetings, the authors revised the scale and then administered it again to other patients to verify the appropriateness of the changes. In conclusion, in a further meeting, agreement was reached on the final version of the scale (PAHS.2).

Future studies may be designed to validate this latest version and evaluate possible further modifications. In the meantime, the PAHS.2 is already available as an interesting phenomenological assessment tool for describing individual cases in qualitative studies.

KEYWORDS: Rating Scales, Psychodiagnostics, Psychopathology, Phenomenology, Hallucinations, AVH, Qualitative Research.

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INTRODUCTION

A version of the scale designed for a phenomenological study of auditory hallucinations was presented in a previous article published on this journal (the Phenomenological Auditory Hallucination Scale, PAHS.1) (Aragona and Maggiora, 2023).

The scale was developed following these basic principles:

1. In psychopathology, the index phenomenon (AVH in our case) is the result of a figure/ground articulation, in which both the person experiencing it and the interviewer collaborate.
2. The index phenomenon can be described in its components (as if it were an object), as well as part of a complex whole. In our case, we can describe the internal characteristics of the AVH (e.g., the personification of the voices, their tone and volume, etc.), the psychopathological background (e.g., delusional state, depressed mood, etc.), the general state of consciousness during listening (e.g., lucid, oneiroid, etc.), observable

behavior (e.g., lip movements, etc.), the patient's position-taking in relation to their own voices, etc.

3. AVHs are experienced by a person in their individual way of being-in-the-world, that is, by a person whose experience of self, their body, others, things, space, and time is particular. This basic experiential structure of subjectivity is essential.
4. The general atmosphere during the interview, as well as the interviewer's emotional reactions, are an integral part of the phenomenon and must be described. Far from being considered spurious subjective reactions of the observer or background noise, they are specifically elicited and are therefore relevant to a complete description of the phenomenological emergence.

This new article presents the second version of the scale (PAHS.2), modified following the revision process described in the methodology.

METHODS

The first version of the Phenomenological Auditory Hallucination Scale (PAHS.1) was presented at a meeting of the Roman Circle of Psychopathology in March 2024. During the discussion, some criticism was raised by the audience. All criticisms and suggestions for changes were taken into account and noted, so that they could be used for future revisions of the scale. From April to September 2024, the scale was subjected to public consultation. Psychiatrists, psychologists, other mental health professionals, and experts by experience participated in the public consultation. The public consultation was conducted at an international level (mainly European and American experts participated). In the meantime, one of the authors has begun presenting the scale during talks at conferences and other meetings, both in Italy and abroad. In this way, further observations were collected that could be used for the revision.

In parallel with this experts consultancy activity, the authors began administering the scale to a small sample of patients (with psychosis, PTSD, and substance-related hallucinosis) to detect any difficulties in the questions of the individual items and/or in the possible answers.

In two subsequent meetings, the authors revised the scale and then administered it again to other patients to verify the appropriateness of the modifications.

Finally, in a further meeting, an agreement was reached on the final version of the scale (PAHS.2).

THE PAHS.2 – STRUCTURE AND DESCRIPTION

The PAHS.2 is a clinician-administered scale. After a first section collecting sociodemographic information, the clinician is requested to evaluate different features of the patient and also of her/his own reaction. In accordance to the idea that hallucinations are emergencies of a figure/background dynamic, information about the patient and the clinician is structured at different levels.

In a logical order, they can be presented as follows:

a) Information about the atmosphere of the clinical encounter and about the clinician's emotional reaction;

b) Behavioral observation of the patient in relation to hallucinations and general behavior (e.g., hearing behavior, soliloquy, perplexity, restlessness);
c) State of consciousness of the patient while hearing hallucinations (e.g., lucid, oneiroid, confuse, etc.);
d) Experience of the lived time (e.g., stagnation, acceleration of the flow of time, etc.);
e) Concomitant psychopathological phenomena (e.g., delusions, depression, etc.);
f) Intrinsic formal features of the hallucinations (e.g., sensoriality, spatialization, personification, temporal mode of onset/disappearance, etc.);
g) Content and modality (e.g., commenting voices, orders, etc.);
h) Formal relation between form and content (e.g., congruence or incongruence);
i) Position-taking in front of the hallucinatory experience (e.g., level of controllability, coping strategies, ownership, insight).

Although questions can be clustered, in the presentation of the scale they are listed without reference to the category to which they belong to. Exceptions are those who are introduced by a general sentence or question. For example, the section asking for the clinician's emotional reaction is introduced by the general statement: "At first contact with the patient, my initial feeling was the following". Then, five kinds of possible emotional reactions follow, like "I experienced an emotional distance/a sense of unfamiliarity", "I felt annoyed/angry", etc. The same descriptors are used later when they are introduced by a different general statement: "At the end of the interview, my feeling is". This double presentation is aimed at distinguishing praecox feeling from post-hoc reflective appraisal. Another example is the general sentence "While hearing voices/sounds, the person appears to be" followed by descriptors such as: "Reliving a past experience, disconnected from the present time", "Experiencing them within a stagnation of the flow of time", etc. (questions aimed at evaluating the experience of lived time).

Moreover, the questions are not ordered following the logical order showed above but following a "practical" order, i.e., considering the structure of a usual clinical inquiry, in which some questions are asked and rated during the interview and others are flagged soon after the interview. This to follow as much as possible the naturalness of the clinical encounter and avoid an excessive length of the interview.

Besides the numerical score, some items may add space for open answers, in an effort to capture qualitative differences that otherwise would remain concealed. Although open answers cannot be treated in statistical analyses, they remain a fruitful source of information for qualitative research.

In total, the items evaluated are 106. See the appendix for a full list of questions/descriptors, answers and scores.

NEXT STEPS

The PAHS.2 was mainly designed for qualitative research, particularly in phenomenological psychopathology. Its main use is to assist clinicians and research in the description of possible different patterns presented by different kinds of hallucinations. For example, previous idealtypical research has found differences between schizophrenic and traumatic auditory hallucinations (Maggiora et al., 2021) that are usually overlooked in studies using common

scales for hallucinations. Our idea is that the PAHS.2 could be useful to highlight these unnoticed differences and help objectify them in different scores in key items. The same should be the case for other forms of hallucinations (e.g., drug-induced, depressive, obsessive hallucinations, etc.). For exploratory studies in this field, the scale is available and ready for use.

A first next step should be the construction of a graphic modality to report the item scores, useful to show a graphic pattern that could be more easily compared to note differences in different kinds of hallucinations.

The other main step is the statistical validation of the scale. It was a deliberate choice to concentrate firstly on the conceptual valuation of the scale, and to submit to the statistical research the instrument only after a conceptual revision. The PAHS.2 is the output of this conceptual revision, which is now ready to be submitted to the research team that will design the validation study.

CONCLUSION

We present here the conceptual revision of the Phenomenological Auditory Hallucination Scale, which is the output of a process that has involved many colleagues in a public consultation.

The scale in its present version (PAHS.2) is already available for qualitative research designed to spot qualitative differences among different kinds of hallucinations.

For more structured studies requiring a validated instrument, the final version will be available after the conclusion of the validation study.

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PHENOMENOLOGICAL AUDITORY HALLUCINATIONS SCALE (PAHS.2)

This clinician-administered scale is designed as a clinical and research tool to elicit specific details regarding the experience of hearing voices and related phenomena.

PERSONAL INFORMATION

Name of the help seeker……

Age (years) …….. **Nationality** ……

Gender
□ Male □ Female Other …… □ Prefer not to say

Years of education …….

Marital/Relationship status

□ Single □ Married or Civil partnership □ Separated/divorced □ Widowed

□ Relationship (cohabitant) □ Relationship (not living together) Other ……..

Employment
□ In paid employment or self-employed □ Undeclared/irregular work □ Doing unpaid or voluntary work
□ Unemployed □ Student
Other ……....……..

Housing
□ Own house □ Family house □ Shared house □ Shelter □ Homeless □ Health residence
Other …….

Living with
□ Parents/Siblings □ Partner/Children □ Cohabitants □ Alone Other
…….

CLINICIAN'S FIRST EMOTIONAL REACTION

At first contact with the person interviewed, my initial feeling was the following:						
1	I experienced an emotional distance/a sense of unfamiliarity	Not at all	A little	Somewhat	Quite a lot	Extremely
2	I felt annoyed/angry	Not at all	A little	Somewhat	Quite a lot	Extremely
3	I found it difficult to be spontaneous	Not at all	A little	Somewhat	Quite a lot	Extremely
4	I felt sad/helpless	Not at all	A little	Somewhat	Quite a lot	Extremely
5	I felt tense/guarded/scared	Not at all	A little	Somewhat	Quite a lot	Extremely
6	I felt emotionally involved/ready to take care	Not at all	A little	Somewhat	Quite a lot	Extremely

PRESENCE OF AUDITORY HALLUCINATIONS

7	Are there behavioural signs of auditory hallucinations?	Never	Sometimes	Often	Most of the time	Always
8	Does the person report hallucinations?	Never	Only after persistent questions	After being asked	Spontaneously, after some time	Spontaneously right away

NUMBER AND KIND OF AUDITORY HALLUCINATIONS

9	Are auditory hallucinations only voices, only sounds/noises, or both?	N.A.	Only voices	Only Sounds/Noises	Both
10	Are they usually single voices or many?	N.A.	Single	Many	
11	How many voices does the person hear now?	N.A.	……		

SENSORIAL MODALITIES

12	While hearing voices/sounds, does the person also perceive images that others do not see?	N.A.	Never	Sometimes	Often	Most of the time	Always
13	While hearing voices/sounds, does the person also perceive odours that others do not perceive?	N.A.	Never	Sometimes	Often	Most of the time	Always
14	While hearing voices/sounds, does the person also experience tactile sensations in the absence of stimulation?	N.A.	Never	Sometimes	Often	Most of the time	Always
15	While hearing voices/sounds, does the person also experience strange movements or sensations within the body?	N.A.	Never	Sometimes	Often	Most of the time	Always
16	If the hallucinatory experience is multisensorial, are the different modalities synchronized?	N.A.	Never (unrelated)	Sometimes (poorly aligned)	Often	Almost always (strongly aligned)	Always (synchronized)

ONSET

17	How old was the person when he/she first started experiencing auditory hallucinations?	N.A.	Age ……..		
18	Did a significant life event occur soon before or at onset?	N.A.	Yes	No	Please specify ……... ……..…

FREQUENCY

19	How often has the person experienced hallucinations in the last week?	Never	Sometimes	Often	Most of the time	Always
20	How frequent are hallucinations during the day?	Absent	Less than 1 hour	1-10 hours	More than 10 hours	Continuous
21	Do they stop when the person is sleeping?	**YES**			**NO**	

STARTING AND ENDING

22	Do the voices/sounds start abruptly?	Not at all (gradually)	A little	Somewhat	Quite a lot	Extremely (abruptly)
23	Do the voices/sounds disappear gradually?	Not at all (quickly)	A little	Somewhat	Quite a lot	Extremely (gradually)

SPATIALITY

24	What part of the patient's body do hallucinations come from?	They are not from the body	From the skin	From the inside of the body (head excluded)	From the head (brain excluded, e.g. face, mouth)	From within the brain
25	From which part of outer space do the hallucinations come?	They are not external	From the pericorporal space	From the surrounding environment	From distant spaces within the perceptual field	They are outside the perceptual field (extracampine)

PERCEPTUAL QUALITY

26	Are the hallucinations perceived vividly?	Not at all (vaguely)	A little	Somewhat	Quite a lot	Extremely (full of details)
27	How loud is their volume?	Not at all (soundless)	A little (whispers, soft sounds)	Somewhat	Quite a lot	Extremely (shouting, etc.)
28	Do hallucinations differ from usual voices/sounds?	Strongly disagree (almost identical)	Disagree	Doubtful	Agree	Strongly agree
29	Are voices like human voices?	**YES**	**NO**	**N.A.**		
	Describe the differences	…… …… …… ……				

LENGTH

30	Are voices long utterances?	Not at all (wordless or no voices)	Very short (just one word)	Short sentences	Long sentences	Very long sentences or uninterrupted speech

PERSONIFICATION

31	Is the hearer able to recognise what/who is generating the hallucinations?	Never	Sometimes	Often	Most of the time	Always
32	What/who is generating them?	…….. …….. ……..				

COMMUNICATION

33	In case of voices, does the hearer understand what they say?	Never	Sometimes	Often	Most of the time	Always
34	Does the hearer dialogue with the voices?	Not at all (He/she just listen to)	A little	Somewhat	Quite a lot	Extremely (He/she continuously responds to the voices)
35	The voices repeat what the hearer thinks/says	Never	Sometimes	Often	Most of the time	Always
36	The voices do not address the hearer (e.g. they talk to each other)	Never	Sometimes	Often	Most of the time	Always
37	The voices comment on what the hearer thinks/says	Never	Sometimes	Often	Most of the time	Always
38	The voices scream at the hearer	Never	Sometimes	Often	Most of the time	Always
39	The voices persecute the hearer	Never	Sometimes	Often	Most of the time	Always
40	The voices give the hearer orders	Never	Sometimes	Often	Most of the time	Always
41	The voices are mocking the hearer	Never	Sometimes	Often	Most of the time	Always

CONTENT OF HALLUCINATIONS

42	Undetectable	Never	Sometimes	Often	Most of the time	Always
43	Ordinary/trivial issues	Never	Sometimes	Often	Most of the time	Always
44	Persecutory	Never	Sometimes	Often	Most of the time	Always
45	Lived traumatic experiences	Never	Sometimes	Often	Most of the time	Always
46	Mystic/religious/ spiritual	Never	Sometimes	Often	Most of the time	Always
47	Messages from dead people	Never	Sometimes	Often	Most of the time	Always
48	Hypochondriac/somatic	Never	Sometimes	Often	Most of the time	Always
49	Grandiose	Never	Sometimes	Often	Most of the time	Always
50	Accusatory/blaming	Never	Sometimes	Often	Most of the time	Always
51	Sexual	Never	Sometimes	Often	Most of the time	Always
52	Amusing	Never	Sometimes	Often	Most of the time	Always
53	Other	…… …… ……				

HEARER'S INDUCED REACTION

54	The hallucinations make the hearer sad	Not at all	A little	Somewhat	Quite a lot	Extremely
55	The hallucinations make the hearer scared	Not at all	A little	Somewhat	Quite a lot	Extremely
56	The hallucinations make the hearer happy	Not at all	A little	Somewhat	Quite a lot	Extremely
57	The hallucinations make the hearer angry	Not at all	A little	Somewhat	Quite a lot	Extremely
58	The hallucinations make the hearer ashamed	Not at all	A little	Somewhat	Quite a lot	Extremely
59	The hallucinations make the hearer feel guilty	Not at all	A little	Somewhat	Quite a lot	Extremely
60	The hallucinations make the hearer perplexed	Not at all	A little	Somewhat	Quite a lot	Extremely
61	The hallucinations make the hearer disgusted	Not at all	A little	Somewhat	Quite a lot	Extremely
62	The hallucinations make the hearer excited	Not at all	A little	Somewhat	Quite a lot	Extremely
63	The hearer does not report any particular reactions	Not at all	A little	Somewhat	Quite a lot	Extremely

FORM/CONTENT CONGRUENCE OR ECCENTRICITY

64	Is the global presentation of the hallucinatory experience bizarre?	Not at all	A little	Somewhat	Quite a lot	Absolutely
65	Are the hallucinations congruent with behaviour?	Never	Sometimes	Often	Most of the time	Always
66	Are the hallucinations congruent with the affective state (e.g. mood)?	Never	Sometimes	Often	Most of the time	Always

DEGREE OF CONTROL

67	Is the hearer able to trigger the hallucinations?	N.A.	Never	Sometimes	Often	Most of the time	Always
68	Is the hearer able to stop the hallucinations?	N.A.	Never	Sometimes	Often	Most of the time	Always
69	Can the hearer refuse to do things that the hallucinations want him/her to do?	N.A.	Never	Sometimes	Often	Most of the time	Always

INSIGHT

70	Does the hearer recognise the hallucinations as a product of his/her own mind?	N.A.	Never	Sometimes	Often	Most of the time	Always
71	Does the hearer recognise the hallucinations as being pathological?	N.A.	Never	Sometimes	Often	Most of the time	Always
72	What does the hearer think about the cause of his/her hallucinations?	……..… ……. ……					

STATE OF CONSCIOUSNESS

73	During the interview, was the hearer's state of consciousness vigilant?	Not at all (obtunded)	A little (drowsy)	Somewhat (partially clouded)	Quite a lot (vigilant)	Extremely (hypervigilant)
74	While experiencing hallucinations, was the state of consciousness lucid?	Not at all (confused)	Oneiroid	Twilight state (crepuscular)	Partially absorbed (wandering, lost in thoughts)	Absolutely (lucid)

OTHER PSYCHOPATHOLOGICAL PHENOMENA

75	Does the hearer report delusions?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
76	Does the hearer present delirium?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
77	Does the hearer report overvalued ideas?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
78	Does the hearer present obsessions?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
79	Is the hearer's mood depressed?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
80	Is the hearer's mood euphoric?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
81	Is the hearer's mood dysphoric?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
82	Does the hearer show perplexity?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
83	Is the hearer experiencing Wahnstimmung (delusional atmosphere)?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
84	Is the hearer restless?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
85	Does the hearer report out-of-body experiences?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
86	Does the hearer show mannerism?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
87	Does the hearer show stereotypies?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
88	Is disorganized speech detectable?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
89	Are post-traumatic nightmares reported?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
90	Is the person anxious?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
91	Is the patient aggressive?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree

INTERSUBJECTIVITY

92	The hearer was relationally open to the interview	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
93	The hearer showed intention to communicate	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
94	During interview, interpersonal contact was attuned	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
95	Are hallucinations more frequent/severe when the hearer is alone?	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree

TEMPORALITY

While hearing hallucinations, the person appears to be:						
96	Reliving a past experience, disconnected from the present time (as in another time frame)	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
97	Experiencing them as part of the present time (time flowing as always)	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
98	Experiencing them within a stagnation of the flow of time (time standing still)	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
99	Experiencing them within an acceleration of the flow of time (extremely high speed of time or in a vortex)	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree
100	Experiencing them in a messianic/prophetic atmosphere (something is going to happen)	Strongly disagree	Disagree	Doubtful	Agree	Strongly agree

CLINICIAN'S EMOTIONAL REACTION AT THE END OF THE INTERVIEW

At the end of the interview, my feeling is:						
101	I experience an emotional distance/a sense of unfamiliarity	Not at all	A little	Somewhat	Quite a lot	Extremely
102	I feel annoyed/angry	Not at all	A little	Somewhat	Quite a lot	Extremely
103	I find it difficult to be spontaneous	Not at all	A little	Somewhat	Quite a lot	Extremely
104	I feel sad/helpless	Not at all	A little	Somewhat	Quite a lot	Extremely
105	I feel tense/guarded/scared	Not at all	A little	Somewhat	Quite a lot	Extremely
106	I feel emotionally involved	Not at all	A little	Somewhat	Quite a lot	Extremely